ANDREW M. PRINCE, M.D., F.A.C.S. - PATIENT REGISTRATION FORM

Name: _____Date of Birth:_____ Gender: M / F

Race: African American / American Indian or Alaska Native / Asian / Native Hawaiian / White / Decline to State

Ethnicity: Hispanic Not Hispanic Decline to state **Primary Language**: _____

Mailing Address: _____
Street Apt/Unit# City State Zip code

Email: _____ Marital Status: Married / Single / Other

Best Contact Phone #(s): _____ _____ _____
HOME WORK CELL

Referring MD: _____
Name Address Phone Fax

Family MD: _____
Name Address Phone FAx

Primary Insurance: _____ ID #: _____

Second Ins. Plan: _____ ID #: _____

Third Ins. Plan: _____ID #: _____

Emergency Contact Name: _____

Relationship: _____Phone #: _____

PHARMACY: _____
Name Phone Fax

I the undersigned give my authorization to treat and assign directly to Andrew M. Prince, MD, FACS, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me and conducting health care operations.

_____ _____
Signature Date

Andrew M. Prince, MD FACS - Medical History Questionnaire

Name_____

What concerns if any do you have about your eyes _____

_____

Have you ever had eye surgery: Y N

If yes, what type of surgery: _____

_____

Current eye meds: _____

_____

All other meds: _____

_____

Medication Allergies: _____

	YES	NO	Details	Family
EYES (poor vision, eye pain, tearing, redness, etc.)				
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)				
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)				
CARDIOVASCULAR (high BP, racing pulse, etc.)				
RESPIRATORY (congestion, wheezing, short of breath, etc.)				
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)				
FEMALES Are you pregnant? Nursing?				

	YES	**NO**	**Details**	**Family**
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)				
SKIN (pimples, warts, growths, rash, etc.)				
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)				
PSYCHIATRIC (anxiety, depression, insomnia)				
ENDOCRINE (diabetes, hypothyroid, etc.)				
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)				
ALLERGIC / IMMUNOLOGICAL (sneezing, swelling, redness, itching, hives, lupus, **HIV**)				
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)				

Do you or any blood relative have any of the following? (Mark "S" for self or "R" for relative)

_____Blindness _____Macular Degeneration _____Glaucoma _____Retinal Detachment

_____Other (please list) _____

Please list all surgical procedures you have had in the past _____

_____

Do you have an optometrist? ____ Yes ____ No, If yes, please list _____

Do you wear glasses or contact lenses? ____ Yes ____ No, If so, for how long? _____

Do you smoke? Yes No If no, have you ever smoked and for how long? _____

Are you pregnant? ____Yes ____ No **If yes, how many months?** _____

Do you use alcohol?_____Yes _____No If yes, how often _____

_____ _____

Signature of Patient or Guardian Date

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government,** it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Home Phone: _____ □ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No
If so, may we leave a message? □ Yes □ No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____
Is this person your Power of Attorney for medical purposes? □ Yes □ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize Andrew M. Prince M.D. to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

Patient Signature: _____ Date: _____

ANDREW M. PRINCE, M.D., FACS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Andrew M. Prince, MD, may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Andrew M. Prince's Notice of Privacy Practice's for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Andrew M. Prince, MD, FACS reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Andrew M. Prince, MD's Privacy Officer at:

Lisa Todd
680 Kinderkamack Rd., Ste 103
Oradell, NJ 07649
Phone: 201-265-9040
Fax: 201-523-9784

With my consent, Andrew M. Prince, MD, may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Andrew M. Prince, MD, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Andrew M. Prince, MD restrict how it uses or discloses my PHI to carry out my TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Andrew M. Prince, MD to the use and disclosure of my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Andrew M. Prince, MD may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name **Date**

Signature on File-Assignment of Benefits-Financial Agreement

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please feel free to ask if you have any questions about our fees, financial policy or your financial responsibility.

1. **MEDICARE:** We will submit claims to Medicare. The patient has a responsibility for the annual deductible and the 20% co-insurance. If there is automatic crossover in place, then your secondary will automatically be billed.
2. **MEDICARE LIFETIME SIGNATURE ON FILE**: I request that my payment of authorized Medicare benefits be made on my behalf to **Andrew M. Prince, MD**, for any services furnished to me by **Andrew M. Prince, MD**. I authorize any holder of medical information about me to release to the Center of Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing information to the insurer or agency shown. **Andrew M. Prince, MD**, accepts the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.
3. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to **Andrew M. Prince, MD**.
4. **RELEASE OF INFORMATION: Andrew M. Prince, MD**, may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease or HIV to any person or corporation (1) which is or may be liable or under contract to **Andrew M. Prince, MD**, for reimbursement for services rendered and (2) any health care provider for continued patient care **Andrew M. Prince MD** may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
5. **REFERRALS:** If your plan requires a referral from your primary care physician, it is **YOUR** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, **YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER**. It is then your responsibility to provide us with the referral within 48 hours or you will personally be responsible for that day's services.
6. **CO-PAYMENTS:** By law we MUST collect your **carrier** designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
7. **SELF-PAY PATIENTS:** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
8. **NON-COVERED SERVICES:** I understand that **Andrew M. Prince, MD,** contracts with health care service plans (ie: HMO, EPO, PPO, etc.), that relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include but are not limited to services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health plan furnishes to the patient along with treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with **Andrew M. Prince, MD** to obtain necessary health care service plan authorization.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by **Andrew M. Prince, MD**, I will pay my account at the time service is rendered or will make financial arrangement satisfactory to **Andrew M. Prince, MD**, for payment. If an account is sent to an attorney for collection, I agree to pay collections expenses and reasonable attorney fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to **Andrew M. Prince, MD**.

WE ACCEPT CHECKS, MASTERCARD, VISA, DISCOVER and AMERICAN EXPRESS.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

_____ _____

PATIENT OR AUTHORIZED PARTY SIGNATURE DATE

_____

PATIENT NAME (PRINT)

Andrew M. Prince, M.D., F.A.C.S.

Ophthalmology & Ophthalmic Surgery
Glaucoma Consultations

178 East 71st Street
New York, NY 10021
Tel: (212) 717-2200
Fax: (212) 717-7377

GLASSES PRESCRIPTION FEE ACKNOWLEDGMENT

PLEASE READ CAREFULLY

For Medicare Patients:

Medicare has mandated that patients be advised that **refraction is NOT paid for or reimbursable through Medicare.** Refraction is the testing necessary for the doctor to write a prescription for glasses. You will be responsible for paying that portion of the examination if you request and are given a NEW prescription for your glasses.

For All Other Private Insurances:

Your insurance may not pay for the testing required to write a prescription for glasses, even with proper referral. If testing you for glasses is necessary or if you request a prescription adjustment, we will perform this service, but you will be financially responsible for this fee.

***This is NOT an agreement to pay. This is simply an acknowledgment that you have been notified that you will be charged, IF you should request a new eyeglass prescription. ***

Charge for refraction (new glasses prescription): $85.00

Patient Name:_____

Signature:_____Date:_____